STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395682	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on review of facility policy, facility documentation, clinical record review, and staff interview it was determined that the facility failed to ensure that residents are free from misappropriation of resident property for 15 of 15 resident (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16). Findings include: Review of facility policy Abuse, Neglect, and Exploitation dated 3/10/25, indicated: The facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Misappropriation the deliberate, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without consent. Review of facility documentation investigation witness statement dated 5/15/25, Licensed Practical Nurse Employee E2, indicated the following: I went to count with LPN Employee E1 from the daylight shift. When we walked into the med room she popped 2 Xanax (alprazolam) out of a residents card, I asked what they were doing because the Residents Xanax is prn and they only get one. LPN Employee E1 stated, I was going to give them one earlier, I'll give it to them now and you can give them one later. I counted with AP LPN Employee E1 and the count was right but when I went through the narcotic book several meds were given twice in a very small time frame. I immediately notified the ADON and Staff Educator. Review of facility documentation investigation witness statements, dated 5/15/25, indicated the following: LPN Employee E2 came up to the office with the units narcotics book and notified ADON (assistant director of nursing) and RN Employee E3 that the nurse they had several suspicious entries in the log and [the employee] was still in the building. After looking at the log and the MARS (medication administration record) of several residents it was concluded that there was probable diversion had occurred. After notifying the NHA and DON (Nursing Home Administrator and Director of Nursing) the police were called. Upon arrival the police officers and myself escorted the LPN Employee E1 to interview them in private. LPN Employee E1 appeared intoxicated/impaired as evidenced by slow slurred speech, unsteady gait while ambulating, difficulty keeping eyes open while conversing . LPN Employee E1 refused to provide urine test. After the police interview was concluded they escorted LPN Employee E1 out of the facility. LPN Employee E1 was instructed by the police to have someone pick them up and that they were not to drive impaired. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility documentation for Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, and R16 Controlled Medication Utilization Record (Narcotic Count Sheet) and MAR's (Medication Administration Record- form used by facilities to document medication administration) showed discrepancies between what was ordered and what was given by LPN Employee E1. Review of Resident R1 clinical record physician orders indicated: tramadol Schedule IV tablet 50 mg; amount to administer 0.5 tab oral, 1/2 tablet q8 hours prn for moderate pain. Further review indicates medication was signed out on narcotics count sheet (2 taken out) but was not indicated on the MAR. Review of Resident R2 clinical record Narcotic Count Sheet indicated: oxycodone immediate 5mg tablet take 1 tablet by mouth every six hours as needed for pain, review of facility documentation indicated two of the doses were not signed off for appropriately by RN Employee E1, with review of the MAR indicated a count sheet was not located during the investigation for Resident R2's oxycodone. Review of Resident R3's MD orders indicated: Review of Resident R3 clinical record physician orders indicated: oxycodone immediate 5mg tablet Give 0.5 tab by mouth as needed for moderate pain. Further review of the clinical record and facility documentation indicated: 2 were signed out but 1 was given. Review of Resident R4 clinical record and Narcotic Count Sheet indicated: alprazolam (Xanax) 0.25 mg tablet 1 tab by mouth every 8 hours as needed. Further review of the clinical record indicated 2 tablets were removed by review of the MAR and the facility documentation indicated 0 were given. Review of Resident R5 clinical record and Narcotic Count Sheet indicated: oxycodone -acet 5 mg - 325mg tablet Give 1 tablet every 8 hours as needed for pain. Review of the MAR indicated that on 5/12/25, 2 were given and 3 were signed out and on 5/14/25, 3 signed out 1 was given. Review of Resident R6 clinical record and Narcotic Count Sheet indicated: alprazolam 1mg tablet give 1 tab by mouth 30 minutes before showers on Thursday and Sunday. Review of the MAR and facility documentation indicated that 2 tablets were signed out but 0 were given. Review of Resident R6 clinical record and Narcotic Count Sheet indicated: alprazolam 0.5mg tablet give 1 tablet by mouth twice daily (hold for sedation), review of facility documentation MAR indicated that 2 were signed out but only 1 was given. Review of Resident R7 clinical record and Narcotic Count Sheet indicated: alprazolam 0.25mg tablet give 1 tablet by mouth every 8 hours as needed. Further review indicated 1 wasted and 0 on the MAR. Review of Resident R7 clinical record and Narcotic Count Sheet indicated: an additional order of alprazolam 0.25mg tablet give 1 tablet by mouth every 8 hours as needed - 2 documented on narcotic sheet but only 1 given. Review of Resident R8 clinical record and Narcotic Count Sheet indicated: alprazolam tablet 0.25mg, 1 tablet once a day, 2 documented on narcotic count sheet 0 given on MAR. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R9 clinical record and Narcotic Count Sheet indicated: lorazepam 0.5mg tablet give 1 tablet by mouth every 8 hours, review of facility documentation narcotic sheet and MAR had two different times for medication being given. Review of Resident R10 clinical record and Narcotic Count Sheet indicated: lorazepam 0.5mg tablet give 1 tab by mouth twice daily 1 pill was signed out by LPN Employee E1 but documented on MAR as another employee giving medication. Review of Resident R11 clinical record and Narcotic Count Sheet indicated: oxycodone 5mg tablet take 1 tablet by mouth every 6 hours as needed. Review of narcotic count sheet indicated 4 tablets were given but 1 was documented as given and the times they were supposedly given did not meet the every 6 hours. Review of Resident R12 clinical record and Narcotic Count Sheet indicated: lorazepam 0.5mg tablet give 1 tablet by mouth every day. Review of facility documentation indicated LPN Employee E1 took out 2 were documented as being given with 1 noted on the MAR and a conflicting time discrepancy between MAR and narcotic sheet. Review of Resident R13 clinical record and Narcotic Count Sheet indicated: lorazepam 0.5mg tablet 1 tablet by mouth every 2 hours as needed. Review of narcotic sheet indicated 6 tabs were documented as given review of MAR failed to identify/include that the medications were given, Review of Resident R14 clinical record and Narcotic Count Sheet indicated: oxycodone 30mg tablet, give 1 table by mouth twice a day. Review of the narcotic sheet showed a discrepancy between the two. Narcotic sheet indicated one dose was given but not document on MAR. Review of Resident R15 clinical record and Narcotic Count Sheet indicated: lorazepam 0.5mg tablet give 1 tab by mouth three times a day. Review of Narcotic sheet indicated 1 tablet given, but medication was not indicated on the MAR. Review of Resident R16 clinical record and Narcotic Count Sheet indicated: oxycodone 5mg tablet, give 1 tab by mouth every 6 hours as needed. Review of the Narcotic sheet indicated 6 tablets were given over 3 days (5/12,5/14,5/15) and 2 days were not documented as given on the MAR. During an interview on 6/18/25, at approximately 3:40 p.m. Nursing Home Administrator, Director of Nursing, were informed that the facility failed to ensure that residents are free from misappropriation of resident property for 15 of 15 resident (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, and R15). 28 Pa. Code 201.20 a(5)b Staff development 28 Pa. Code 201.29 (c) Resident rights

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility documentation, the facility failed to train an employee in abuse for one of three employees (LPN Employee E1). Findings include: Review of facility training documentation for LPN Employee E1 failed to include a current (completed within the year) abuse, neglect misappropriation training. The most recent training provided was from 2022. During an interview on 6/18/25, at approximately 3:45 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure abuse training for LPN Employee E1. 28 Pa. Code 201.20 a(5)b Staff development 28 Pa. Code 201.29 (c) Resident rights

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility documentation, and staff interview it was determined that the facility failed to report an allegation of misappropriation. Findings include: Review of facility policy Abuse, Neglect, and Exploitation dated 3/10/25, indicated: The facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Misappropriation the deliberate, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without consent. Review of facility documentation investigation witness statement (from Licensed Practical Nurse Employee E2), dated 5/15/25, indicated the following: I went to count with the LPN Employee E1 from the daylight shift. When we walked into the med room she popped 2 Xanax (alprazolam) out of a residents card, I asked what they were doing because the Residents Xanax is prn and they only get one. LPN Employee E1 stated, I was going to give them one earlier, I'll give it to them now and you can give them one later. I counted with LPN Employee E1 and the count was right but when I went through the narcotic book several meds were given twice in a very small time frame. I immediately notified the ADON and Staff Educator. Review of facility documentation investigation witness statements, dated 5/15/25, indicated the following: LPN Employee E2 came up to the office with the units narcotics book and notified ADON (assistant director of nursing) and RN Employee E3 that the nurse they took over for had several suspicious entries in the log and was still in the building. After looking at the log and the MARS (medication administration record) of several residents it was concluded that there was probable diversion had occurred. After notifying the NHA and DON (Nursing Home Administrator and Director of Nursing) the police were called. Upon arrival the police officers and myself escorted LPN Employee E1 to interview them in private. LPN Employee E1 appeared intoxicated/impaired as evidenced by slow slurred speech, unsteady gait while ambulating, difficulty keeping eyes open while conversing . LPN Employee E1 refused to provide urine test. After the police interview was concluded they escorted LPN Employee E1 out of the facility. LPN Employee E1 was instructed by the police to have someone pick them up and that they were not to drive impaired. During an interview on 6/16/25, at approximately 10:30 a.m. Nursing Home Administrator (NHA) confirmed that the facility had an incident with LPN Employee E1 and that they did not report the incident to the State Survey Agency , because their corporate office stated they did not have to. During an interview on 6/18/25, at approximately 3:45 p.m. the NHA, and Director of Nursing were informed that the facility failed to report an allegation of misappropriation to the State Survey Agency as required. 28 Pa. Code 201.20 a(5)b Staff development 28 Pa. Code 201.29 (c) Resident rights